

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14244

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No.
Registered No. 3582
St. Ward

2. FULL NAME

(a) Residence No. 2609 Madison St. 20 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 21-1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 9 18

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer) (Porter)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER William Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Edward Brown (Address) 3840 Indiana Ave

15. FILED APR 11 1930 Year & Month REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1930

17. No Physician in Attendance
HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
82A (Non Traumatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) H. H. H.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 74 W

IF NOT AT PLACE OF RESIDENCE

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kerner, M. D.

410. 1930 (Address) Dep Corner

*State the DISEASE CAUSING DEATH, if in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Hodgenville, Ky. April 10 1930

20. UNDERTAKER ADDRESS

Wacker Kilders 2331 So Bilway

PAPER RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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